State of California Department of Consumer Affairs

BOARD OF BEHAVIORAL SCIENCES
400 R STREET, SUITE 3150, SACRAMENTO, CA 95814
TELEPHONE: (916) 445-4933 TDD: (916) 322-1700
WEBSITE ADDRESS: http://www.bbs.ca.gov

MARRIAGE, FAMILY, AND CHILD COUNSELOR PSYCHOTHERAPY VERIFICATION

(Optional Hours)

Use a separate form for each psychotherapist verifying hours of group or individual psychotherapy received that may be credited toward the experience requirement for licensure as a marriage, family, and child counselor. ***Psychotherapy performed by the applicant's supervisor shall not be credited. No erasures or corrections may be made. If any error has been made, complete a new form. Make certain that the form is complete and correct.*** *Psychotherapy verification forms are to be submitted by the applicant with his or her application for licensure.* ****** *The* ***address*** *you enter on this form is public information, and will be released to the public upon request.*

APPLICANT**:** Complete Section I ***PSYCHOTHERAPIST*****:** Complete Section II

I. APPLICANT: (*Please type or print clearly in ink.*)

I, _____, hereby authorize _____ to provide the Board of Behavioral
print name psychotherapist

Sciences with the information requested in Section II, as these hours may be counted as part of my supervised experience for licensure. I understand that this information will be maintained in confidence and used solely to assist the Board with the evaluation of my application for licensure. _____
Signature Date

*Address: _____
Number and Street City State Zip Code

Business Telephone: (_____) _____ Residence Telephone: (_____) _____

2. BBS File Number: _____; Check one: MFCC Trainee ☐ MFCC Intern ☐

Registered MFCC Intern Number: _____ Date Issued: _____

II. PSYCHOTHERAPIST: (*Please type or print clearly in ink.*)

1. Dates the applicant received Group, Marital or Conjoint, Family or Individual Psychotherapy in accordance with Business and Professions Code Section 4980.43(d)(2).

From _____ to _____ Therapy Hours _____ x 3= _____

2. PSYCHOTHERAPIST:

_____ _____ _____ _____
Type of License License Number State of License Date Originally Licensed

If M.D., were you certified in Psychiatry by the American Board of Psychology and Neurology or have you completed a residency in Psychiatry during the entire period of supervision? Yes ☐ No ☐ Date Board Certified: _____

Address: _____
Number and Street City State Zip Code

Daytime Telephone Number: (_____) _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____ _____
Date Print Name Signature and Title